

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare of Cuyahoga Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 300 East Bath Road Cuyahoga Falls, OH 44223	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0697 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of imaging reports, review of hospital records, and facility policy review, the facility failed to ensure complaints and origins of pain were comprehensively evaluated and timely reported to a physician. This resulted in Actual Harm on 07/11/25 when Resident #150, who had severely impaired cognition and who was dependent on staff for all activities of daily living (ADLs), was identified to have bruising and pain in her right hip and was observed by staff grabbing her right thigh. Resident #150's pain medication was changed from as needed to routine, and Resident #150 continued to have pain with no evidence of a thorough pain assessment or assessment of range of motion to the affected extremity. Between 07/11/25 and 07/16/25, Resident #150 continued to have breakthrough pain. On 07/16/25, Resident #150's pain was rated at a 10 out of 10 (worst possible pain) and the physician[SS1] was notified and ordered an x-ray examination, and it was determined Resident #150 had a fractured right hip. This affected one Resident (#150) of three residents reviewed for accidents and change in condition. The facility census was 50. Findings include: Review of the closed medical record for Resident #150 revealed diagnoses including but not limited to, dementia, an unspecified fracture of shaft of left tibia (04/11/25), unspecified fracture of right femur (07/17/25), Type II diabetes mellitus, repeated falls, unspecified protein-calorie malnutrition, and hereditary and idiopathic neuropathy. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] for Resident #150 revealed a Brief Interview for Mental Status (BIMS) score of 4 which indicated severely impaired cognition. Review of the ADLs for Resident #150 revealed she used a wheelchair and required maximum assist for dressing and personal hygiene, was incontinent of bowel and bladder, and was dependent on staff for toileting, bathing, rolling left to right, and transferring. Review of the physician order for Resident #150 revealed an order dated 04/11/25 for Percocet (Oxycodone with Acetaminophen) [a narcotic medication used to treat moderate to severe pain] oral tablet 5-325 milligram (mg) two tablets by mouth every four hours as needed for severe pain. Review of Resident #150's care plan dated revised 04/24/25 revealed an ADL self-performance deficit related to diagnosis of diabetes mellitus, congenital postural curvature of the spine, history of a right hip fracture, and a history of a left tibia and fibula fracture in April 2025. Interventions included but were not limited to skin inspection weekly with any concerns reported to the nurse, staff to turn and reposition in bed as needed, transfers using the Hoyer (mechanical lift used to safely transfer individuals with limited mobility), and report declines in ADLs to physician. Review of a skin assessment dated [DATE] for Resident #150 revealed intact skin, with no areas of concern or impending wound development. Review of the witness statement dated 07/07/25 and 07/08/25 from Certified Nursing Assistant (CNA) #259 revealed Resident #150 ate about 50-75% of meals and was noted to grab her leg due to pain. Resident #150 was noted to be in pain while changing her and was medicated but continued to complain of pain throughout the day despite medication. Review of the nursing progress note dated 07/09/25 timed at 8:18 P.M. revealed Resident #150 reported severe pain all over her body and 2 tablets of as needed (PRN) Percocet 5-325 mg tablets were administered as ordered. Review of the nursing progress note dated 07/10/25 timed at 9:02 A.M. for Resident #150 indicated two tablets of Percocet 5-325 mg oral tablet were given for severe pain. Repositioning and distraction were noted to be ineffective. A note timed at 3:19 P.M. noted an additional dose of Percocet was given to Resident #150 for severe pain in her left leg, and repositioning and distraction were noted to be ineffective. An additional note timed at 9:23 P.M. revealed two tablets of Percocet 5-325 mg oral tablet were given to Resident #150 due to severe pain. Review of the 07/11/25 nursing progress noted timed at 3:13 P.M. for Resident #150 revealed two tablets of Percocet 5-325 mg oral tablet were given for pain in her legs and repositioning and distraction were noted to be ineffective. An additional note timed at 4:08 P.M. revealed Resident #150 had a bruise on her left leg. Resident #150 was noted to squeeze the leg in the area of the bruise when in pain. Resident #150 stated she squeezes her leg to make it feel better. No further discoloration was noted. A new order for Percocet was received from the nurse practitioner. Review of the physician order dated 07/11/25 revealed a new order for Oxycodone 10 mg by mouth five times a day for pain related to encounter for orthopedic aftercare. An additional order dated 07/11/25 for Acetaminophen (an over-the-counter mild pain reliever) 500 mg by mouth five times a day for pain. The Oxycodone and Acetaminophen were scheduled to be administered at the same times. Review of the 07/11/25 nursing progress note timed at 9:00 P.M. revealed two tablets of Percocet 5-325 mg oral tablets were given to Resident #150 for reports of severe pain. Review of change of</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents were free from significant medication errors. This affected one resident (#112) out of three residents reviewed for insulin administration. The facility identified ten residents who required insulin. The facility census was 50. Findings include: Review of Resident #112's medical record revealed an admission date of 02/22/21 with diagnoses including chronic kidney disease, heart failure, type two diabetes mellitus, and protein calorie malnutrition. Review of Resident #112's care plan revised on 08/16/21 revealed the resident was at risk for hypoglycemic (low blood sugar) and hyperglycemic (elevated blood sugar) episodes related to diabetes. Listed interventions included to monitor blood sugar levels as ordered, monitor for signs and symptoms of hypoglycemia and hyperglycemia, and to administer insulin as ordered. Review of Resident #112's physician orders revealed an order dated 06/18/25 for Novolog (a short acting insulin) inject 3 units subcutaneously twice daily for type two diabetes mellitus with diabetic neuropathy. Additional instructions stated to hold the dose for a blood sugar less than 110. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #112 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Resident #115 was assessed to require minimal or supervising assistance for activities of daily living (ADLs) and hygiene needs. Resident #112 was identified to require insulin injections on seven out of seven days of the assessment reference period. Observation on 08/06/25 at 11:42 A.M. revealed Licensed Practical Nurse (LPN) #231 obtained Resident #112's blood glucose level. LPN #231 cleansed her hands and the glucometer. LPN #231 proceeded to wipe Resident #112's finger with an alcohol swab, inserted the test strip into the glucometer, and used a single-use lancet to prick Resident #112's right pinky finger with the lancet. LPN #231 wiped the first drop of blood off with clean gauze and then placed the test strip over a small drop of Resident #112's blood to obtain a blood glucose result of 93. LPN #231 then retrieved the multidose vial of Resident #112's Novolog insulin from the medication cart, cleansed the top of the vial with an alcohol swab, and drew up four units of insulin using an insulin syringe. LPN #231 then performed hand hygiene and returned to Resident #112's room. LPN #231 administered the four units of insulin subcutaneously to Resident #112, injecting the insulin into the resident's right upper arm. Hand hygiene was performed after contact with the resident. Interview with the Director of Nursing (DON) on 08/06/25 at 1:30 P.M. verified the significant medication error with LPN #231 administering insulin to Resident #112 when the medication should have been held per provider order. The DON assessed Resident #112 for any signs and symptoms of hypoglycemia. Resident #112 displayed no negative effects from receiving the insulin dose. The DON documented the medication error in the electronic medical record and informed the resident and the physician of the occurrence. No new orders were obtained. Review of facility policy titled, Medication Administration and Management revised 06/2019, revealed authorized staff members administer subcutaneous injections. The nurse will review physician orders and follow the eight rights of medication administration. This deficiency represents non-compliance investigated under Complaint Number 2581097.</p>		